South Carolina Budget & Control Board
Employee Insurance Program
MONEYPLU$ Accounts

PLAN YEAR: _____

CHANGE IN STATUS (CIS) FORM

Social Security Number	Name (Please Print) Last	First	MI

Home/Mailing Address	Street	City	State	ZIP Code

Type Of Change Requested

Change Existing Account (Select accounts you wish to change.)	**Start Account** (Select accounts you wish to begin.)	**Terminate Account** (Select accounts you wish to end.)
__ Medical Spending Account*	__ Medical Spending Account*	__ Medical Spending Account*
__ Dependent Care Account	__ Dependent Care Account	__ Dependent Care Account
__ Limited-use Medical Spending Account	__ Limited-use Medical Spending Account	__ Limited-use Medical Spending Account

*** Are you currently using the EZ REIMBURSE® MasterCard® Card with your MONEYPLU$ Medical Spending Account?** __ Yes __ No

Qualified Change Events (Check and date all that apply.)

CIS Effective date of Event	***CIS Effective first of the month following Event***	***Tax Filing Status (please check one)***
Event Date Event	**Event Date Event**	**Dependent Care Accounts only**
_____ Marriage	_____ Dependent not eligible (marriage, age, loss of dependent status)	___ Married filing separately (maximum - $2,500)
_____ Birth	_____ Spouse begins Employment	
_____ Adoption	_____ Spouse ends Unpaid Leave	
_____ Placement of Custody	_____ Divorce	___ Married filing jointly (maximum - $5,000)
_____ Spouse ends Employment	_____ Legal separation	
_____ Spouse begins Unpaid Leave	_____ Change in Day Care Provider	
CIS Effective day after date of Event	_____ Employee begins Unpaid Leave	___ Single, head of household (maximum - $5,000)
Event Date Event	_____ Employee ends Unpaid Leave	
_____ Spouse passed away	_____ Change from full- to part-time (self, spouse, dependent)	
_____ Dependent passed away	_____ Change from part- to full-time (self, spouse, dependent)	

Payroll Calculation Summary

To be completed by Benefits Administrator	Medical Spending Account	Dependent Care Account	Limited-use Medical Spending Account
A. Current Total Annual Contribution			
B. New Total Annual Contribution			
C. Amount Contributed Thus Far			
D. Amount Needed to Meet New Annual Goal [B minus C]			
E. Number of Paychecks Remaining			
F. New Per-Pay-Deduction Amount [D divided by E]			
Benefit Effective Date (Refer to **Qualified Change Events** above.)			
Payroll Effective Date			

I certify that on the date(s) indicated, I incurred the Change in Status event(s) selected above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. I understand that the amount of salary deduction will include the items specified above and will continue in effect, unless I terminate employment or file an approved Change in Status with the Benefits Administrator within 31 days of the event. I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any Account or my failure to sign or accurately complete this form. **Current deductions will continue for any accounts that are not changing.**

Employee Signature	Date

FOR OFFICE USE ONLY

Signature below affirms that the item(s) checked comply with IRS and Account plan guidelines. This employee meets all eligibility requirements, and is eligible to participate in the MONEYPLU$ Program. Return processed CIS form via ❑ FAX ❑ MAIL (check one).

Payroll Center/Agency	Mailing Address	City, State, ZIP Code	Fax Number

Benefits Administrator Approval Signature	Date	Phone Number

Please return within 24 hours of completion. The payroll change should not be made until you receive fax confirmation that the change has been made in Fringe Benefits Management Company's system. Return completed form via fax to 1-850-514-5805 or mail to FBMC, P.O. Box 1878, Tallahassee, FL 32303. If you have questions, you may contact our Customer Service Department, at 1-800-342-8017, for assistance. Please allow up to 10 business days for processing.

Date FBMC Received Approved CIS Form from BA _____ *Date FBMC Data Entered CIS Form* _____ *Date FBMC Sent Processed Form to BA* _____